



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Fondren Orthopedic

Respondent Name

Amguard Insurance Co

MFDR Tracking Number

M4-16-1253-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Code J0702 is a payable code and should be paid according to the Medicare Fee Schedule."

Amount in Dispute: \$6.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bill in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett, 6404 International Parkway, Suite 2300, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 24, 2015	J0702	\$6.99	\$6.78

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 23 – This procedure is not paid separately
 - BL – this bill is a reconsideration of a previously reviewed bill

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 23 – "This procedure is not paid separately." 28 Texas Administrative Code §134.203(b) states,

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

- (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

Review of the applicable Medicare payment policies and CCI edits found no indication that the service in dispute is not separately payable. The carriers' denial is not supported. The service in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.203(d) states,

The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

- (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
- (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS;

The service in dispute is a "J" code. Review of the Texas 3rd quarter DMEPOS fee schedule finds no listing. Therefore the service in dispute is subject to Rule 134.203(d)(2). The allowable for the service in dispute is calculated as follows: Texas Medicaid Allowable for the date of service in dispute is \$5.42. This amount multiplied by 1.25 = \$6.78. This is the maximum allowable based on applicable fee guideline.

3. The total allowable for the service in dispute is \$6.78. The carrier previously paid \$0.00. The remaining balance of \$6.78 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$6.78.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$6.78 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February , 2016
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.